DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

HIGHLIGHTS

June 2009

TESTIMONY

AIG for Healthcare Inspections Testifies on Endoscopy Reprocessing

Assistant Inspector General (AIG) for Healthcare Inspections, John Daigh, M.D., appeared before the U.S. House Veterans' Affairs Subcommittee on Oversight and Investigations to discuss Office of Inspector General (OIG) report, *Healthcare Inspection, Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities*. This review was requested by the VA Secretary, the Chairmen and Ranking Members of VA oversight committees, and other Members of Congress as a result of reprocessing errors that placed Veterans at risk of viral infections at VA Medical Centers (VAMCs) in Augusta, GA, Miami, FL, and Murfreesboro, TN. Dr. Daigh told the Subcommittee that OIG's unannounced inspections conducted at 42 randomly selected medical facilities showed that VA needs to address serious management issues regarding industrial processes. Inspectors found that fewer than half of the selected facilities were in compliance with directives on availability of standard operating procedures at reprocessing sites and documentation of staff training and competency. Dr. Daigh was accompanied by George Wesley, M.D., Jerome Herbers, M.D., and Limin Clegg, Ph.D., from OIG's Office of Healthcare Inspections (OHI).

VHA Quality Management Subject of Senate Veterans' Affairs Committee Hearing

Julie Watrous, RN, Director of OHI's Combined Assessment Program, testified before the U.S. Senate Committee on Veterans' Affairs on the above-cited report and two others, *Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration (VHA) Facilities Fiscal Year 2008*; and *Healthcare Inspection, Evaluation of the Veterans Health Administration's National Patient Safety Program*. Ms. Watrous described OIG's recommendations to improve quality management through increased compliance with Joint Commission standards and VHA requirements, and to improve the National Patient Safety (NPS) Program's effectiveness and oversight. She discussed the need to standardize processing, strengthen monitoring, and hold staff accountable when internal controls fail as in the case of endoscope reprocessing. Ms. Watrous was accompanied by the AIG for Healthcare Inspections and Victoria Coates, Regional Director of the Atlanta OHI.

OIG REPORTS

Systemic Compliance Failures Found in Endoscopy Reprocessing Practices

In addition to findings outlined by the AIG for Healthcare Inspections in his testimony, OIG found that VHA's Clinical Risk Assessment Advisory Board has been effective in providing guidance to VHA leadership on disclosure on adverse events to Veterans. OIG made recommendations to ensure compliance with reprocessing directives, explore possibilities for improving the reliability of reprocessing with experts, and review VHA's organizational structure for needed changes to implement quality controls and ensure compliance with directives. [Click for Report.]

OIG Evaluates National Patient Safety Program

OIG evaluated VHA's NPS Program, determining if VHA's NPS Program has been effective in preventing inadvertent harm to patients receiving VHA care and whether it has provided efficient and effective coordination, oversight, and continuous improvement. VHA's 1998 creation of the NPS Program was an important and positive step towards expanding existing patient safety activities. Since 1998, VHA's NPS Program has been the foundation for many national and international patient safety initiatives. However, OIG noted several opportunities to strengthen the NPS Program and made recommendations aimed to achieve programmatic effectiveness and oversight improvement. [Click for Report.]

Inadequate Analysis, Poor Administration Noted in VA/SPAWAR Agreement for Information Technology Services

At the request of the VA Secretary and Steve Buyer, Ranking Minority Member, U.S. House Committee on Veterans' Affairs, OIG reviewed the Interagency Agreement (IAA) between VA's Office of Information and Technology, Office of Enterprise Development, and the Department of Navy, Space and Naval Warfare Systems Center (SPAWAR). Reviewers found that all parties entered into the IAA without an adequate analysis to determine whether it was in the best interest of the Government, as required by the Federal acquisition regulations. Moreover, OIG determined that neither party complied with the terms and conditions of the IAA. OIG suggested that VA re-evaluate the IAA and determine whether it is in the best interest of VA to continue obtaining services through this type of agreement, and if so, issue a new IAA that complies with VA policy. [Click for Report.]

Insufficient Testing of VHA Patient Record Software Found

OIG's Office of Audit and OHI evaluated the testing and deployment of the Computerized Patient Record System (CPRS) version 27 (v27) at the request of the former VA Secretary. The project management team's software development methodology for testing and implementing CPRS v27 did not effectively mitigate risks, associated software functionality defects, and the potential adverse impacts on patient safety. OIG made recommendations to improve the quality and depth of field testing. [Click for Report.]

VBA Large Retroactive Payments at Risk for Fraud
The objective of an OIG special review of large retroactive payments at select VA Regional Offices (VARO) was to determine to what extent the Veterans Benefits Administration (VBA) and VAROs processing large retroactive payments have designed and implemented effective policies, procedures, and mechanisms to prevent and detect fraudulent activity. OIG's review detected no instances where altered or forged medical examination documentation and information improperly supported retroactive payments of $25,000 or above. However, OIG found that VBA lacks sufficient guidance directing VAROs to maintain accountability over its official date stamps. Additionally, medical document reviews focus on the technical sufficiency and completeness of a claim and do not focus on identifying potentially fraudulent medical information. VBA will continue to be vulnerable to these types of fraud-related activities if internal control weaknesses are not improved throughout VAROs. [Click for Report.]

Pharmacy Contract Management Needs Strengthening
An OIG audit of VA's Consolidated Mail Outpatient Pharmacy (CMOP) determined that VA needs to improve CMOP contract management. The audit revealed that although the National CMOP Office generally complied with Federal and VA acquisition requirements when developing, competing, and monitoring contracts, CMOP managers did not always ensure that the contracts were effective, economical, or that they adequately protected VA's contractual interests. One contract reviewed did not meet Federal and VA acquisition requirements, which if followed could have saved VA $724,426. Three other contracts revealed that CMOPs were susceptible to overpaying for contract services, valued at $40.7 million, due to poor monitoring controls. OIG made recommendations to strengthen contract development controls as well as improve oversight of contract monitoring. [Click for Report.]

Accountability Lacking for Non-controlled Drug Inventory
OIG conducted an audit to determine how accurately VHA could account for inventories of non-controlled drugs at increased risk for waste and diversion in its health care facilities. OIG found that VHA cannot accurately account for its non-controlled drug inventories because it has neither implemented nor enforced sufficient controls to ensure pharmacy inventory practices are standardized and pharmacy data is accurate. The accurate and complete data needed to account for these drugs is not available. Furthermore, VHA's Veterans Health Information System and Technology Architecture lacks the capability to capture information on some drugs that are returned to and restocked by a facility when drugs cannot be delivered to the Veteran. VHA needs to improve its ability to account for non-controlled drugs to reduce the risk of waste and diversion. [Click for Report.]

Better Scheduling Practices Could Reduce Incomplete C&P Exams
An OIG audit identified opportunities for VHA and VBA to increase the number of completed Compensation and Pension (C&P) exams and determine the causes of some canceled C&P exams. To reduce the number of incomplete C&P exams, VHA needs to improve exam-scheduling procedures, the quality of C&P exam requests, and quality assurance review procedures. Reducing the number of incomplete C&P

exam requests, currently around 17 percent, will help ensure that claims decisions are handled more efficiently and Veterans receive timely disability benefit payments. [Click for Report.]

Flaws Noted in Fee Basis Program at Connecticut Healthcare System
OIG conducted an inspection of the VA Connecticut Healthcare System (HCS) after a complainant alleged mismanagement of the Fee Basis Program, which allows VA to authorize Veterans' medical care in the community when VA cannot provide all of the necessary care and services. Inspectors substantiated the existence of flaws in the pre-authorization process for fee-based care, but determined that VA physicians were not self-referring or benefiting financially from Fee Basis Program claims. Inspectors acknowledged that managers initiated new procedures to improve oversight prior to the inspection, but also made recommendations to ensure sustained oversight and to eliminate the appearance of self-referrals and conflicts of interest. [Click for Report.]

CRIMINAL INVESTIGATIONS

Company and Executives Indicted for Off-Label Marketing Violations
A medical supply company, a wholly owned subsidiary, and four corporate executives were indicted on 97 felony and misdemeanor counts of introduction into interstate commerce of adulterated and misbranded medical devices with intent to defraud, introduction into interstate commerce of adulterated and misbranded medical devices, false statements, and conspiracy. The four executives have already signed approved plea agreements for their roles in the marketing and uses of Norian XR in an unapproved manner. An OIG, Food and Drug Administration Criminal Investigation Division, Health and Human Services OIG, and Defense Criminal Investigative Service investigation initiated in 2005 revealed that the company, which was the world's largest maker of bone-related medical devices, promoted an unapproved use for the bone void filler Norian XR. Early in the investigation, OIG coordinated a nationwide, simultaneous mass interview of current sales representatives and their supervisors in the spine division to secure information regarding the company's illegal marketing practices. It was revealed that the company was teaching the sales representatives to promote Norian XR in an off-label manner. Consequently, the sales representatives trained spine surgeons to use the product inappropriately, resulting in three patient deaths.

Houston VAMC Employee Sentenced for Theft of Transportation Subsidies
A Houston, TX, VAMC employee was sentenced to 10 years' incarceration after pleading guilty to felony theft. An OIG investigation revealed that the defendant embezzled over $400,000 in transportation subsidies intended for a vanpool program benefitting VAMC employees.

West Los Angeles VA Employees Charged with Theft in Transit Benefit Program
Ten West Los Angeles VA employees were charged with grand theft during an OIG investigation involving the misuse of transportation reimbursement vouchers from the Transit Benefit Program (TBP). To date, seven of the ten defendants have pled guilty and were sentenced to a combination of probation, up to 50 hours'

community service, and ordered to pay restitution. The OIG investigation identified widespread abuse of TBP regulations by VA employees, confirming that at least 28 VA employees had violated TBP rules, including the 10 charged. The frauds included workers who drove personal vehicles to work, were separated from VA, or were using Government funds to hold a seat in a van pool, all while fraudulently claiming eligibility and accepting vouchers for public transportation. The loss to VA from these ten employees is $16,600. Other VA employees who abused the TBP have been removed from the program. Since the inception of the investigation, 29% of the program's 624 participants have withdrawn or been removed. To date, VA has saved $47,612 in unused TBP vouchers from the 182 employees who have to date withdrawn from the program.

Southeastern Arizona HCS Employee Sentenced for Theft
A HCS employee was sentenced to 27 months' incarceration and ordered to pay restitution of $365,816 to the Southern Arizona VA HCS after previously pleading guilty to theft of public money, wire fraud and mail fraud. The defendant was the Clinical Director of Education and Training for two VAMCs and stole VA funds through various schemes.

Jackson VAMC Nurse Indicted for Drug Diversion
A Jackson, MS, VAMC nurse was indicted for diverting Schedule II narcotics for personal use. An OIG investigation revealed that the defendant had been diverting narcotics prescribed to inpatient Veterans for over a year. The employee also falsified VA computerized patient records by inputting fictitious orders to assist him in diverting additional narcotics.

Waco Nursing Assistants Arrested for Patient Abuse
A Waco, TX, VAMC nursing assistant was arrested for assault of a disabled individual after an OIG investigation revealed that the employee repeatedly slapped a cognitively impaired patient. A second Waco VAMC nursing assistant was arrested on the same charge after an OIG investigation revealed that this employee repeatedly punched a VAMC psychiatric patient causing lacerations to the Veteran's head.

Veteran and Others Indicted for Fraud
A Veteran, his spouse, and a Veterans' Service Organization (VSO) representative were indicted for wire fraud, theft, misprision of a felony, and conspiracy. An OIG investigation determined that the Veteran and his spouse made false statements to VA and the Social Security Administration (SSA) concerning the Veteran's inability to ambulate. During the course of the investigation the VSO was found to have "coached" the Veteran and shredded documents that would have exposed the fraud. The loss to VA is $413,509 and the loss to SSA is $165,234.

Former Augusta, Georgia, VAMC Nurse's Aide Indicted for Workers Compensation Fraud
A former Augusta, GA, VAMC nurse's aide was indicted for making false statements to obtain Federal workers' compensation program benefits. An OIG and Department of Labor (DOL) OIG investigation determined that after leaving the

VAMC on a work related injury in 1987, the defendant failed to notify DOL that he was also working as a local home improvement contractor while continuing to receive workers' compensation benefits. The loss to VA is approximately $292,000.

Veteran Indicted for Education Benefits Fraud
A Veteran was indicted for theft of Government funds and false statements after an OIG investigation determined that he fraudulently received VA education benefits from March 2004 to July 2007. The defendant submitted forged VA monthly certifications reporting that he was attending school when, in fact, he was not attending a VA-approved curriculum. The loss to VA is approximately $21,000.

Wife of Deceased Veteran Charged with False Claims
A civil complaint was filed charging the wife of a deceased Veteran with violation of the False Claims Act. A civil judgment was granted against the defendant ordering payment of $263,244 to the Government. An OIG investigation revealed that the defendant submitted fraudulent information to VA when she applied for Dependency and Indemnity Compensation benefits.

North Carolina Veteran Sentenced in "Stolen Valor" Investigation
A Veteran was sentenced to 6 months' incarceration, 2 years' probation, and ordered to pay $65,956 in restitution after pleading guilty to theft of Government property. An OIG investigation determined that the defendant submitted a fraudulent DD-214 in order to receive VA benefits. The defendant fraudulently claimed to have received the Purple Heart, Korean Service Medal, Air Force Overseas Ribbon, and a Good Conduct Medal while reportedly serving in Korea during the Korean War. The Veteran never served in Korea during the Korean War.

Defendant Sentenced for Theft of Veteran's Identity
A non-Veteran was sentenced to 33 months' incarceration, 36 months' probation, and ordered to pay VA restitution of $99,607 after pleading guilty to stealing the identity of a Vietnam Veteran and using that identity to receive health care benefits. The investigation further determined that the defendant was a fugitive, having escaped from prison in Alabama in 1978 after serving less than 1 year of a 44-year prison sentence for robbery and grand larceny.

Veteran Taken into Custody after Making Threats to VA
A Veteran was taken into custody by OIG, with assistance from the local sheriff's department and the U.S. Secret Service, and involuntarily committed to a local hospital after making threats against VA and VA employees. The investigation disclosed that the Veteran telephoned a VA office in Muskogee, OK, and made threatening statements to a VA employee. When the defendant was contacted by OIG he made additional threats against VA and its employees, including the OIG. The defendant also stated that in the past he had sent threatening correspondence to the President.

Veteran Wanted for Sexual Assault of a Child Arrested with OIG Assistance
A Veteran was arrested at the Houston, TX, VAMC by local police with the assistance of OIG on two separate arrest warrants for aggravated sexual assault of a child.

(original signed by:)
GEORGE J. OPFER
Inspector General